SAMPLE

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

60-DAY ASSESSMENT

Indicate Service: _____Residential Support _____Supported Employment _____ Prevocational
_____Personal Assistance _____ Day Support

ESTIMATED DURATION: **NOT TO EXCEED 60 DAYS**

Individual:_____Medicaid Number:_____

Code:_____ Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Start Date:_____ End Date:_____ Quarterly Review Dates: _____ _____ _____ _____

CSP SELECTED GOAL/ DESIRED OUTCOME: *To develop an ongoing plan of training and supports that will best address _____'s interests and personal goals for living in the community.*

OBJECTIVES *(Examples in italics. Delete any that do not apply. Add any additional on pages 2 & 3.)*	TARGET DATE	ACTIVITIES/ STRATEGIES *(Examples in italics. Delete any that do not apply. Add any additional on pages 2 & 3.)*
1) _____ *will participate in an assessment of his/her abilities, strengths, interests and areas in which assistance and/or training is needed. The following areas (allowable for the above checked service) will be assessed:*		*Staff will evaluate all areas indicated and complete the required documentation of observations and assessments. Staff will identify personal preferences that work/do not work for _____.* **Frequency:** *Staff will assess and document the need for overnight supervision (if applicable).* **Frequency:**
2) _____ *will receive any needed assistance in the following areas (allowable for the above checked services):*		*Staff will provide needed assistance and specialized supervision (if applicable) with activities pertinent to this service throughout the assessment period.* **Frequency:**
3) _____ *will participate in an orientation to the service site(s) and agency/situational procedures regarding fires and other emergencies.*		*Staff will orient _____ to the applicable service site(s) and emergency procedures.* **Frequency:**

Individual:_____Service:_____ Start Date:_____

OBJECTIVES *(Examples in italics. Delete any that do not apply. Add any additional.)*	TARGET DATE	ACTIVITIES/ STRATEGIES *(Examples in italics. Delete any that do not apply. Add any additional.)*
4) _____ *will receive needed assistance/supervision for the following known health/safety issue(s):*		*Staff will perform the following procedures to assist _____ with his/her health/safety issues:* **Frequency:**
5) _____ *will receive needed assistance/supervision for the following known behavioral issue(s):*		*Staff will perform the following procedures to assist _____ with his/her behavioral issue(s):* **Frequency:**
6) _____ will receive needed assistance/supervision for the following known communication/language barriers:		*Staff will perform the following procedures to assist _____ with his/her communication issue(s):* **Frequency:**
7) _____ *will participate in the development of a written person-centered ISP that includes strategies that will best support the achievement of _____'s goals as identified on the CSP.*		*Staff, _____, case manager, and family members will develop specific objectives, activities, and strategies that correspond to the selected goals on the CSP and match _____'s desires, interests and support needs.*

Individual:_____ Service:_____ Start Date:_____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual:_____ Service:_____ Start Date:_____

TOTAL HOURS/ UNITS PER WEEK_____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*